State of Delaware: Highmark BlueSelect POS

Coverage Period: 07/01/2018 - 06/30/2019

Coverage for: Individual + Family | **Plan Type:** POS

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage you can visit **www.highmarkbcbsde.com** or call **1-844-459-6452**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at **www.highmarkbcbsde.com** or call **1-844-459-6452** to request a copy

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network provider: **$0**; Out-of-Network provider: **$300** individual/**$900** family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Out-of-network professional emergency services and any service with a copay are covered before you meet your out-of-network deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers preventive services, without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out–of–pocket limit for this plan?	Network provider Medical: **$500** individual/**$1,500** family; Network provider Prescription Drug: **$2,100** individual/ **$4,200** family. Out-of-Network provider Medical: **$1,500** individual/**$4,500** family; Out-of-Network provider Prescription Drug: Not Applicable.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Premiums, balance billing charges, health care this plan does not cover, coinsurance on certain services and penalties for failure to obtain precertification.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Will you pay less if you use a network provider?	Yes. See **www.highmarkbcbsde.com**, or call **1-844-459-6452** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What Will You Pay		Limitations, Exceptions & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay/visit	30% coinsurance	Preauthorization is required for certain services. If you don't get preauthorization, benefits will be denied.
	Specialist visit	10% coinsurance	30% coinsurance	Preauthorization is required for certain services. If you don't get preauthorization, benefits will be denied.
	Preventive care/screening/ immunization	No charge	Pap lab, blood antigens test, mammograms and lead screenings: 30% coinsurance. All other services: Not Covered	Coverage is limited by age, gender and risk parameters as identified in Highmark Delaware's Preventive Health Guidelines. Refer to **www.highmarkbcbsde.com** or call **1-844-459-6452** for specific information. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.

Common Medical Event	Services You May Need	What Will You Pay		Limitations, Exceptions & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	Lab: No Charge X-ray and Machine Testing: 10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits will be denied.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com or call **1-800-939-2142**	Generic drugs	$8 copay/prescription for 30-day supply (retail or mail order); $16 copay/ prescription for 90-day supply (participating retail or mail order)	Reimbursement limited to in-network allowable amount minus applicable copay	Up to 30-day fills at retail or mail order for non-maintenance drugs; 90-day fills for maintenance drugs available at participating pharmacies or mail order only, maintenance drugs filled as 30-day supply incur penalty at fourth fill; under Choice Program, you pay applicable copay plus difference between generic and brand when generic equivalent is available. Erectile dysfunction (ED) drugs are not covered unless medically necessary for conditions other than ED. Prescription drugs with an over-the-counter equivalent are not covered. Qualified members ages 40 - 75 receive generic low to moderate dose statins at no cost. No charge for diabetic supplies purchased through the prescription plan. One copay applies for multiple diabetic medications filled at a 90-day participating retail pharmacy or Express Scripts Pharmacy, if purchased at the same time.
	Preferred brand drugs	$28 copay/prescription for 30-day supply (retail or mail order); $56 copay/prescription for 90-day supply (participating retail or mail order)	Reimbursement limited to in-network allowable amount minus applicable copay	
	Non-preferred brand drugs	$50 copay/prescription for 30-day supply (retail or mail order); $100 copay/ prescription for 90-day supply (participating retail or mail order)	Reimbursement limited to in-network allowable amount minus applicable copay	

Common Medical Event	Services You May Need	What Will You Pay		Limitations, Exceptions & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
	Specialty drugs	Copay based on whether drug is generic, preferred, or non-preferred	Not covered	First fill can be at retail; future fills must be through specialty pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Preauthorization is required for certain outpatient surgical procedures. If you don't get preauthorization, benefits will be denied.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Preauthorization is required for certain outpatient surgical procedures. If you don't get preauthorization, benefits will be denied.
If you need immediate medical attention	Emergency room care	$50 copay/visit	$50 copay/visit	In-network or out-of-network copayment is waived if admitted. Care must be rendered within 48 hours of onset of symptoms.
	Emergency medical transportation	$25 copay/occurrence	$25 copay/occurrence	None
	Urgent care	10% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits will be denied.
	Physician/surgeon fee	10% coinsurance	30% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits will be denied.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance for intensive outpatient care; $5 copay/office visit	30% coinsurance	None
	Inpatient services	10% coinsurance	30% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits will be denied.

Common Medical Event	Services You May Need	What Will You Pay		Limitations, Exceptions & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you are pregnant	Office visit	10% coinsurance	30% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Limited to 100 visits per plan year. Preauthorization is required. If you don't get preauthorization, benefits will be denied.
	Rehabilitation services	10% coinsurance	30% coinsurance	Limited to 60 days per condition for physical and occupational therapy; 60 days per condition for speech therapy.
	Habilitation services	Not Covered	Not Covered	You must pay 100% of these expenses.
	Skilled nursing care	10% coinsurance	30% coinsurance	Limited to 120 days of care. Benefits renew after 180 days without care. Preauthorization is required. If you don't get preauthorization, benefits will be denied.
	Durable medical equipment	10% coinsurance	30% coinsurance	Preauthorization is required for certain durable medical equipment. If you don't get preauthorization, benefits will be denied.
	Hospice services	10% coinsurance	30% coinsurance	Limited to 365 days of care.
If your child needs dental or eye care	Children's eye exam	$10 copay/visit	Not Covered	Coverage is limited to 1 routine visit every 12 months.
	Children's glasses	Not Covered	Not Covered	You must pay 100% of these expenses.
	Children's dental check-up	No charge under Delta Dental or Dominion Dental	20% coinsurance under Delta Dental; not covered under Dominion Dental	Delta Dental: $1,500 maximum per person per plan year; Dominion Dental: no maximum.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Glasses
- Habilitation services
- Long-term care (non-hospice)
- Routine foot care (unless medically necessary)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care (30 visits per plan year)
- Dental care (removal of bony impacted teeth; limited accidental injuries)
- Hearing aids (one hearing aid, per ear, every 3 years up to age 24)
- Infertility treatment (lifetime maximum: $10,000 medical and $15,000 prescription drug)
- Non-emergency care when traveling outside the U.S. (primary care referral; plan preauthorization)
- Private-duty nursing (non-hospice; limited to 240 hours in a 12-month period)
- Routine eye care (Adult; limited to one routine vision exam every 24 months)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov. You can also contact the plan at 1-844-459-6452. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, Highmark Blue Cross Blue Shield Delaware at 1-844-459-6452 or www.highmarkbcbsde.com. Additionally, a consumer assistance program can help you file an appeal. Contact the Delaware Department of Insurance/Consumer Assistance Program, 841 Silver Lake Blvd., Dover, DE 19904 or 302-674-7300 (local), 1-800-282-8611 (toll free) or consumer@state.de.us.

Does this Coverage Provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this Coverage Meet the Minimum Value Standard? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

For more information about limitations and exceptions, see the plan or policy document at **www.highmarkbcbsde.com** or by calling **1-844-459-6452.**

Language Access Services:

Arabic (العربية): 1-800-489-8933 اتصل برقم. إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان

Chinese (繁體中文): 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-489-8933.

French (Français): Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-489-8933.

French Creole (Kreyòl Ayisyen): Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-489-8933.

German (Deutsch): Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer 1-800-489-8933.

Italian (Italiano): In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-489-8933.

Japanese (日本語): 日本語を話される場合、無料の言語支援をご利用いただけます。1-800-489-8933 まで、お電話にてご連絡ください。

Korean (한국어): 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-489-8933 번으로 전화해 주십시오.

Persian-Farsi (فارسی): اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-489-8933 تماس بگیرید

Polish (Polski): Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-489-8933.

Portuguese (Português): Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-489-8933.

Russian (Русский): Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-489-8933.

Spanish (Español): Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-489-8933.

Tagalog (Tagalog): Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-489-8933.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible:** $0
- **Specialist coinsurance:** 10%
- **Hospital (facility) coinsurance:** 10%
- **Obstetric care coinsurance:** 10%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$560**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible:** $0
- **Specialist coinsurance:** 10%
- **Hospital (facility) coinsurance:** 10%
- **Diagnostic test (blood work) coinsurance:** 0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$100
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$560**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible:** $0
- **Specialist coinsurance:** 10%
- **Hospital (facility) coinsurance:** 10%
- **Diagnostic test (x-ray) coinsurance:** 10%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$80
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$140**

The plan would be responsible for the other costs of these EXAMPLE covered services.